



## 98TH GENERAL ASSEMBLY

### State of Illinois

2013 and 2014

HB4681

by Rep. Greg Harris

#### SYNOPSIS AS INTRODUCED:

See Index

Amends the Medical Assistance Article of the Illinois Public Aid Code. In provisions requiring the Department of Healthcare and Family Services to issue a purchase of care solicitation for Accountable Care Entities (ACE), makes the following changes: (i) extends the number of months an ACE shall be paid care coordination fees on a per member per month basis from "the first 18 months of operation" to "the first 24 months of operation"; (ii) extends the time period an ACE shall be paid on a pre-paid capitation basis for all medical assistance covered services from "in months 19 through 36 of operation" to "in months 25 through 48 of operation"; (iii) provides that in the fifth (rather than the fourth) and subsequent years of operation, unless the ACE selects a shorter period, an ACE shall convert to a Managed Care Community Network (MCCN); and (iv) provides that (a) the Department shall not require an ACE to connect to the Illinois Health Information Exchange (ILHIE) or to an Illinois regional Health Information Exchange that is connected to the ILHIE until the fifth and subsequent years of operation, unless the ACE selects a shorter period; and (b) in the third year and subsequent years of program operation, the Department shall establish an annual process to allow an ACE to expand its system capacity and number of participating providers and to provide an opportunity for the ACE to increase enrollment levels. Effective immediately.

LRB098 18428 KTG 53565 b

FISCAL NOTE ACT  
MAY APPLY

A BILL FOR

1 AN ACT concerning public aid.

2 **Be it enacted by the People of the State of Illinois,**  
3 **represented in the General Assembly:**

4 Section 5. The Illinois Public Aid Code is amended by  
5 changing Section 5-30 as follows:

6 (305 ILCS 5/5-30)

7 Sec. 5-30. Care coordination.

8 (a) At least 50% of recipients eligible for comprehensive  
9 medical benefits in all medical assistance programs or other  
10 health benefit programs administered by the Department,  
11 including the Children's Health Insurance Program Act and the  
12 Covering ALL KIDS Health Insurance Act, shall be enrolled in a  
13 care coordination program by no later than January 1, 2015. For  
14 purposes of this Section, "coordinated care" or "care  
15 coordination" means delivery systems where recipients will  
16 receive their care from providers who participate under  
17 contract in integrated delivery systems that are responsible  
18 for providing or arranging the majority of care, including  
19 primary care physician services, referrals from primary care  
20 physicians, diagnostic and treatment services, behavioral  
21 health services, in-patient and outpatient hospital services,  
22 dental services, and rehabilitation and long-term care  
23 services. The Department shall designate or contract for such

1 integrated delivery systems (i) to ensure enrollees have a  
2 choice of systems and of primary care providers within such  
3 systems; (ii) to ensure that enrollees receive quality care in  
4 a culturally and linguistically appropriate manner; and (iii)  
5 to ensure that coordinated care programs meet the diverse needs  
6 of enrollees with developmental, mental health, physical, and  
7 age-related disabilities.

8 (b) Payment for such coordinated care shall be based on  
9 arrangements where the State pays for performance related to  
10 health care outcomes, the use of evidence-based practices, the  
11 use of primary care delivered through comprehensive medical  
12 homes, the use of electronic medical records, and the  
13 appropriate exchange of health information electronically made  
14 either on a capitated basis in which a fixed monthly premium  
15 per recipient is paid and full financial risk is assumed for  
16 the delivery of services, or through other risk-based payment  
17 arrangements.

18 (c) To qualify for compliance with this Section, the 50%  
19 goal shall be achieved by enrolling medical assistance  
20 enrollees from each medical assistance enrollment category,  
21 including parents, children, seniors, and people with  
22 disabilities to the extent that current State Medicaid payment  
23 laws would not limit federal matching funds for recipients in  
24 care coordination programs. In addition, services must be more  
25 comprehensively defined and more risk shall be assumed than in  
26 the Department's primary care case management program as of the

1 effective date of this amendatory Act of the 96th General  
2 Assembly.

3 (d) The Department shall report to the General Assembly in  
4 a separate part of its annual medical assistance program  
5 report, beginning April, 2012 until April, 2016, on the  
6 progress and implementation of the care coordination program  
7 initiatives established by the provisions of this amendatory  
8 Act of the 96th General Assembly. The Department shall include  
9 in its April 2011 report a full analysis of federal laws or  
10 regulations regarding upper payment limitations to providers  
11 and the necessary revisions or adjustments in rate  
12 methodologies and payments to providers under this Code that  
13 would be necessary to implement coordinated care with full  
14 financial risk by a party other than the Department.

15 (e) Integrated Care Program for individuals with chronic  
16 mental health conditions.

17 (1) The Integrated Care Program shall encompass  
18 services administered to recipients of medical assistance  
19 under this Article to prevent exacerbations and  
20 complications using cost-effective, evidence-based  
21 practice guidelines and mental health management  
22 strategies.

23 (2) The Department may utilize and expand upon existing  
24 contractual arrangements with integrated care plans under  
25 the Integrated Care Program for providing the coordinated  
26 care provisions of this Section.

1           (3) Payment for such coordinated care shall be based on  
2 arrangements where the State pays for performance related  
3 to mental health outcomes on a capitated basis in which a  
4 fixed monthly premium per recipient is paid and full  
5 financial risk is assumed for the delivery of services, or  
6 through other risk-based payment arrangements such as  
7 provider-based care coordination.

8           (4) The Department shall examine whether chronic  
9 mental health management programs and services for  
10 recipients with specific chronic mental health conditions  
11 do any or all of the following:

12                   (A) Improve the patient's overall mental health in  
13 a more expeditious and cost-effective manner.

14                   (B) Lower costs in other aspects of the medical  
15 assistance program, such as hospital admissions,  
16 emergency room visits, or more frequent and  
17 inappropriate psychotropic drug use.

18           (5) The Department shall work with the facilities and  
19 any integrated care plan participating in the program to  
20 identify and correct barriers to the successful  
21 implementation of this subsection (e) prior to and during  
22 the implementation to best facilitate the goals and  
23 objectives of this subsection (e).

24           (f) A hospital that is located in a county of the State in  
25 which the Department mandates some or all of the beneficiaries  
26 of the Medical Assistance Program residing in the county to

1 enroll in a Care Coordination Program, as set forth in Section  
2 5-30 of this Code, shall not be eligible for any non-claims  
3 based payments not mandated by Article V-A of this Code for  
4 which it would otherwise be qualified to receive, unless the  
5 hospital is a Coordinated Care Participating Hospital no later  
6 than 60 days after the effective date of this amendatory Act of  
7 the 97th General Assembly or 60 days after the first mandatory  
8 enrollment of a beneficiary in a Coordinated Care program. For  
9 purposes of this subsection, "Coordinated Care Participating  
10 Hospital" means a hospital that meets one of the following  
11 criteria:

12 (1) The hospital has entered into a contract to provide  
13 hospital services to enrollees of the care coordination  
14 program.

15 (2) The hospital has not been offered a contract by a  
16 care coordination plan that pays at least as much as the  
17 Department would pay, on a fee-for-service basis, not  
18 including disproportionate share hospital adjustment  
19 payments or any other supplemental adjustment or add-on  
20 payment to the base fee-for-service rate.

21 (g) No later than August 1, 2013, the Department shall  
22 issue a purchase of care solicitation for Accountable Care  
23 Entities (ACE) to serve any children and parents or caretaker  
24 relatives of children eligible for medical assistance under  
25 this Article. An ACE may be a single corporate structure or a  
26 network of providers organized through contractual

1 relationships with a single corporate entity. The solicitation  
2 shall require that:

3 (1) An ACE operating in Cook County be capable of  
4 serving at least 40,000 eligible individuals in that  
5 county; an ACE operating in Lake, Kane, DuPage, or Will  
6 Counties be capable of serving at least 20,000 eligible  
7 individuals in those counties and an ACE operating in other  
8 regions of the State be capable of serving at least 10,000  
9 eligible individuals in the region in which it operates.  
10 During initial periods of mandatory enrollment, the  
11 Department shall require its enrollment services  
12 contractor to use a default assignment algorithm that  
13 ensures if possible an ACE reaches the minimum enrollment  
14 levels set forth in this paragraph.

15 (2) An ACE must include at a minimum the following  
16 types of providers: primary care, specialty care,  
17 hospitals, and behavioral healthcare.

18 (3) An ACE shall have a governance structure that  
19 includes the major components of the health care delivery  
20 system, including one representative from each of the  
21 groups listed in paragraph (2).

22 (4) An ACE must be an integrated delivery system,  
23 including a network able to provide the full range of  
24 services needed by Medicaid beneficiaries and system  
25 capacity to securely pass clinical information across  
26 participating entities and to aggregate and analyze that

1 data in order to coordinate care.

2 (5) An ACE must be capable of providing both care  
3 coordination and complex case management, as necessary, to  
4 beneficiaries. To be responsive to the solicitation, a  
5 potential ACE must outline its care coordination and  
6 complex case management model and plan to reduce the cost  
7 of care.

8 (6) In the first 24 ~~18~~ months of operation, unless the  
9 ACE selects a shorter period, an ACE shall be paid care  
10 coordination fees on a per member per month basis that are  
11 projected to be cost neutral to the State during the term  
12 of their payment and, subject to federal approval, be  
13 eligible to share in additional savings generated by their  
14 care coordination.

15 (7) In months 25 ~~19~~ through 48 ~~36~~ of operation, unless  
16 the ACE selects a shorter period, an ACE shall be paid on a  
17 pre-paid capitation basis for all medical assistance  
18 covered services, under contract terms similar to Managed  
19 Care Organizations (MCO), with the Department sharing the  
20 risk through either stop-loss insurance for extremely high  
21 cost individuals or corridors of shared risk based on the  
22 overall cost of the total enrollment in the ACE. The ACE  
23 shall be responsible for claims processing, encounter data  
24 submission, utilization control, and quality assurance.

25 (8) In the fifth ~~fourth~~ and subsequent years of  
26 operation, unless the ACE selects a shorter period, an ACE

1 shall convert to a Managed Care Community Network (MCCN),  
2 as defined in this Article, or Health Maintenance  
3 Organization pursuant to the Illinois Insurance Code,  
4 accepting full-risk capitation payments.

5 (9) The Department shall not require an ACE to connect  
6 to the Illinois Health Information Exchange (ILHIE) or to  
7 an Illinois regional Health Information Exchange that is  
8 connected to the ILHIE until the fifth and subsequent years  
9 of operation, unless the ACE selects a shorter period.

10 (10) In the third year and subsequent years of program  
11 operation, the Department shall establish an annual  
12 process to allow an ACE to expand its system capacity and  
13 number of participating providers and to provide an  
14 opportunity for the ACE to increase enrollment levels.

15 The Department shall allow potential ACE entities 5 months  
16 from the date of the posting of the solicitation to submit  
17 proposals. After the solicitation is released, in addition to  
18 the MCO rate development data available on the Department's  
19 website, subject to federal and State confidentiality and  
20 privacy laws and regulations, the Department shall provide 2  
21 years of de-identified summary service data on the targeted  
22 population, split between children and adults, showing the  
23 historical type and volume of services received and the cost of  
24 those services to those potential bidders that sign a data use  
25 agreement. The Department may add up to 2 non-state government  
26 employees with expertise in creating integrated delivery

1 systems to its review team for the purchase of care  
2 solicitation described in this subsection. Any such  
3 individuals must sign a no-conflict disclosure and  
4 confidentiality agreement and agree to act in accordance with  
5 all applicable State laws.

6 During the first 2 years of an ACE's operation, the  
7 Department shall provide claims data to the ACE on its  
8 enrollees on a periodic basis no less frequently than monthly.

9 Nothing in this subsection shall be construed to limit the  
10 Department's mandate to enroll 50% of its beneficiaries into  
11 care coordination systems by January 1, 2015, using all  
12 available care coordination delivery systems, including Care  
13 Coordination Entities (CCE), MCCNs, or MCOs, nor be construed  
14 to affect the current CCEs, MCCNs, and MCOs selected to serve  
15 seniors and persons with disabilities prior to that date.

16 (h) Department contracts with MCOs and other entities  
17 reimbursed by risk based capitation shall have a minimum  
18 medical loss ratio of 85%, shall require the MCO or other  
19 entity to pay claims within 30 days of receiving a bill that  
20 contains all the essential information needed to adjudicate the  
21 bill, and shall require the entity to pay a penalty that is at  
22 least equal to the penalty imposed under the Illinois Insurance  
23 Code for any claims not paid within this time period. The  
24 requirements of this subsection shall apply to contracts with  
25 MCOs entered into or renewed or extended after June 1, 2013.

26 (Source: P.A. 97-689, eff. 6-14-12; 98-104, eff. 7-22-13.)

1           Section 99. Effective date. This Act takes effect upon  
2    becoming law.

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Statutes amended in order of appearance

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305 ILCS 5/5-30